

# THE CHIRONIAN.

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VOL. XXVI

APRIL, 1910

NO. 10

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## THE WIDENING SPHERE OF EXPLORATORY INCISION.\*

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Any medical or surgical resource is to be judged and applied not only by its intrinsic but also by its comparative merit. In cancer, for instance, we judge our therapeutic resources—surgical removal, X-ray, radium, trypsin, the recently introduced serum, etc., etc.—not only by their intrinsic values, but we select one or another according to our view of its value as compared with each other known resource. In considering each resource we must not lose sight of the danger of administration any more than of its power to relieve. Surgical procedures are, *per se*, almost daily gaining in safety; operations which five years ago had a considerable mortality are to-day almost without risk and while we thought that technique had reached its limit of improvement some years ago we find the progress of each year to be so marked that he who rests upon the laurels of the past is soon outstripped.

One of the most important results of this never-ending progress toward absolute safety is that the field of comparative usefulness of each procedure widens in inverse ratio with the decrease of risk. To illustrate: The time is not far remote when abdominal section for removal of simple abdominal growths had a mortality of ten per cent., even in the hands of our best men. At that time the physician or surgeon was bound to judge whether or not his patient sustained a risk of more than ten per cent. if she retained her tumor or depended upon some expedient other than the surgical one. If the risk was less than ten per cent. by the medical or expectant or other method of treatment, then certainly no operation should be advised.

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\*Read before the Hom. Med. Society of the County of New York.

In short, it is well recognized that improved technique has lowered mortality and has thereby widened the sphere of applicability and usefulness of many if not all surgical procedures.

It seems to us that this broadened sphere of usefulness applies to no operation more strongly than to exploratory incision in relation to the diseases peculiar to women, and, in fact, to all intra-abdominal conditions. The diagnosis of pelvic and abdominal conditions is notoriously liable to error. It is based upon a history which is often incomplete and sometimes intentionally misleading, upon the findings of an examination which at best is indirect, and gives only vague and imperfect impressions to the most skilled examiner. He may find abnormal growths, malposition of organs, limitation of mobility, tenderness, or the external evidences of inflammation or infection, but the interpretation of these findings and of this history is so difficult that his diagnosis becomes almost a guess rather than a logical deduction.

Now on the other side of this question let us consider for a moment the outcome of most of the pelvic and abdominal lesions which have assumed such proportions that they bring the patient to the physician. It is true that there are some acute conditions which are either self-limited in their course or are so amenable to hygienic or therapeutic measures that they are unlikely to exert a destructive influence upon important organs or upon life itself, and which if their exact nature were known in any given case they would still receive some general treatment which gives as good a result as could possibly be reached. But this is not the case with more than a very small proportion of pelvic and abdominal lesions. It may be said as a broad statement that the vast majority of pelvic and abdominal diseases are chronic and progressive, and that they are ultimately destructive in their results. They may not *always* be destructive of life, but they *often* destroy life, and when they spare the individual they destroy organs which are more or less essential to health and happiness. This is particularly the case with those intra-pelvic lesions which send women to the physician. They, as a rule, result in destruction of the greatest of all her functions, namely, that of procreation; her vigor and activity disappear, pain and a host of nervous symptoms rob her of the charm which goes with health and beauty, and the most unfortunate part of all this history is that these lesions ultimately reach a stage where no medical or surgical resource can restore the health, which only a few weeks or months before was her most valuable inheritance.



The list of destructive lesions is too long for recital and discussion at this time. It includes the new growths, the infections and the malpositions in their ultimate results. In the upper abdomen it includes the various forms of ulceration, gastric and duodenal, also the new growths of the intestine, the kidney and all the abdominal organs, as well as the concretion formations resulting from infections of the biliary tract.

Now all or nearly all these lesions which ultimately impair health, destroy the function of organs, rob the patient of happiness, and, finally, shorten the term of life, pass through a considerable period during which they are curable. Not only this, but the curable period is in nearly all cases of considerable duration *after* nature has served notice upon the patient that something is wrong. The method by which cure could be effected during this period is not material, sometimes it is strictly by medical means, sometimes by hygienic means, sometimes by the use of physical therapy, and sometimes by conservative surgical procedure.

In some cases this curable period lasts only a few days, in others it is measured by months and years, but in nearly all if the disease is not intelligently treated during this period it ends in destruction either of function, health or life. During this period the physician has his opportunity, provided he knows the lesion. During this period the conservative operation is applicable and will often set right a condition which if allowed to progress will do irreparable damage, and we may say in passing, that truly conservative surgery is not confined to the pelvis, but finds also a wide field in the upper abdomen.

Now it is an unfortunate fact that in a very large number of cases this curable period, if we may use that expression, is allowed to slip away and become lost forever. The *physician* often sees this, and though his mouth may be closed out of deference to the feelings of the family and the patient, but perhaps more particularly by his consideration for the physicians who preceded him, still he knows that there was a time after symptoms had developed when intelligent management of the case with full knowledge of the conditions would have resulted in arrest or cure of the disease. It is the surgeon, however, who more frequently perhaps feels the sting which comes to any right thinking professional man when he meets the case where a valuable life must be lost because the curable period of some internal lesion has been allowed to pass by without the right thing

having been done simply because no one knew what was the matter.

So far as our observation goes there are two main causes for the sacrifice of this period, the first cause being that patients sometimes do not go to the physician early enough. The symptoms do not seem to them urgent enough to demand the physician's advice. Into this idea there undoubtedly enters the natural reluctance to submission to a searching examination. In many cases the subject is a woman who refrains from the examination from those reasons which are familiar to us all. There is then not only the repugnance which you and I feel toward giving ourselves up to another, but also that modesty which is more particularly woman's which helps to defer the day of consultation.

During the past year we have had a striking example of this where three patients with uterine cancer at the inoperable stage walked into the hospital for their first consultation without the remotest idea that anything serious was the matter. These were ignorant women of the lower classes, but the same thing does occur now and then among the better educated.

The second cause of neglect to do the right thing during the curable period of abdominal and pelvic lesions applies unfortunately to the great majority of cases in which this period is allowed to slip away. More unfortunately still, we are unable to lay this cause at the patient's door. We may as well admit that the greatest cause of failure to preserve life and function in chronic abdominal and pelvic diseases which are at one time curable, and are ultimately destructive, is the failure of the physician to make a correct, positive, diagnosis and apply the available remedies. This statement may seem like a harsh criticism, but it is absolutely true, and while some improvement is taking place as the years go on, it is a fact that many practitioners are constantly failing to grasp the golden opportunity for cure which is offered by this curable period. We are frank to admit that the defeats which stand out most prominently in our own experience were in cases in which while waiting to arrive at a positive diagnosis the disease progressed beyond the curative stage. The trouble with the physician when he commits this error is, of course, not that he lacks the desire to cure his patient nor is it so much a lack of personal skill as it is the inaccuracy of external methods of diagnosis of internal, particularly abdominal and pelvic, lesions. Our text-books have reiterated for decades the same methods of pelvic and abdominal diagnosis, and the majority



of practitioners feel that when these methods have been applied with skill and thoroughness that the last word has been said and that time alone—the further progress of the case—is the only thing to be relied upon. Now in many cases this is all right, but there remain a large number of cases in which it is all wrong. This method of thought and practice had its origin years ago when exploratory incision meant a very appreciable mortality. No wonder that a diagnostic method, which in itself showed a mortality of, say ten per cent., was reserved and used only as a last resort. No wonder that the public in those days shrank from operation of any sort, and that the physician could not and would not urge so formidable procedure as exploratory incision unless the case was very certainly a surgical one. But it is high time for us to forget those days. They are gone forever and now there is hardly a town of any size in this broad land which has not one or more men who can make a hundred exploratory incisions without the loss of life. Actual inspection and direct palpation of the diseased abdominal structures will almost positively determine the nature of the lesion. Why then should we wait and examine and re-examine for weeks and months while in so many cases the curable period slips away forever. The public are rapidly losing their exaggerated fear of the knife, and they are placing a higher and higher value upon the early diagnosis and prompt remedy of whatever nature. Why should we not in our doubtful cases turn more quickly to the short, quick, safe exploratory incision. Every person present can recall many cases where prompt exploratory incision would have pointed the way toward saving a patient's life, and where the lack of it allowed a progressive lesion to terminate life. Permit us to refer to three illustrative cases which have fallen under our own observation recently; they all chance to be kidney cases.

The first, a middle-aged woman, was under the charge of one of the most renowned physicians and surgeons on the Pacific Coast. She complained of some obscure abdominal symptoms, was examined on a number of occasions and no conclusion arrived at; she was advised to change climate and came to this city under the care of one of the members of this society, who advised immediate exploratory incision, as he found an enormous mass, the nature of which he could not determine. Exploratory incision revealed a sarcomatous kidney, which had changed from the condition of being impalpable to that of being inoperable within six or eight weeks.

The incision was closed, and we just succeeded in getting the patient home alive. What would an exploratory incision six weeks previously have meant to this patient and her family?

A second case was a gentleman from Central New Jersey who, without urinary symptoms, but with some pain in his right side, became rapidly cachectic, lost weight and developed a slow fever. Examination revealed a large mass in the right upper abdomen, the nature of which we could not determine. Exploratory incision resulted in removal of a kidney which was normal except that its convex border was the site of a septic embolus which had produced an abscess, and was upon the point of rupture into the abdomen.

In a third case which occurred within the present week we came near falling into the very error which we are trying to warn against, namely, we nearly wasted the curable period in the effort to make our diagnosis positive and accurate. A middle-aged woman came to the office with evidence of an enormous right kidney, a history of having passed urinary calculi, apparently quite sick. We advised, and appointed for, the catheterization of the opposite kidney, and for a radiograph to determine the presence or absence of stone. Before twelve hours had elapsed she was taken very much worse, and was ultimately hurried into the hospital. Our examination was last Friday, and our operation, namely, an exploratory incision into the abdominal cavity, through the right rectus, was performed at twelve o'clock Saturday night. We determined through this incision the presence of a fairly normal left kidney, and as the right kidney was far too large to remove, through the loin our anterior incision was extended, and after two hours of the most trying effort the kidney containing a large stone and over a pint of pus was removed. The abdomen was found infected by a perforation of the kidney capsule. It was wiped clean and drained and the patient is recovering. Had we waited to make an exact diagnosis, an autopsy would have been in order.

In conclusion, permit us to reiterate that exploratory incision, primarily for diagnostic purposes, is far too frequently underated and neglected. It is a safe, positive procedure which patients will tolerate if only the conditions are intelligently explained to them, and while we do not advocate the least relaxation in the use and study of external methods of diagnosis we do urge the more prompt and general employment of exploratory incision purely as a means of diagnosis in doubtful abdominal and pelvic cases.



## THE IMPORTANCE OF MORE CAREFUL EXAMINATION IN DISEASES OF THE RECTUM.

Dr. Orlando R. Von Bonnewitz.

Hospital statistics show that thirty per cent. of all the people have some sort of rectal trouble. One-third then of the newly graduated doctor's first patients may be one of those cases. If you asked a majority of physicians of numerous years' practice to diagnose and outline a modern treatment for most of these cases, you would find how carefully the subject had been overlooked during their course of instruction.

The student may have seen a few cases of hæmorrhoids operated by clamp and cautery, but this takes an elaborate equipment, skill and all modern hospital facilities, and is, therefore, out of the question.

Salves and medicines have never cured hæmorrhoids permanently and never will, but the day of the clamp and cautery, burning, crushing or strangulating by tying has passed, and well it is for humanity that it has. The modern methods of injection, which is painless, bloodless, and permanent, is so perfect in the hands of a skillful operator that it leaves nothing to be desired.

It is nothing more than fair to the new graduate that his education should include all the modern methods, and by this I mean methods he will be able to use successfully should he see a case of this sort early in his practice, and be able to do what the other doctors have not succeeded in doing—*cure* his case and get a start on the high road to success.

It is perhaps unfortunate that this treatment was brought into disrepute by advertising doctors early in its career, and while some developed skill in its use, a very great many failed and faked the people, simply trying to get what money they could out of them. Proctology is now upon such a sound basis that its development is fast and surely placing it where it deserves. The perfection of new instruments for the perfect examination of the rectum and colon has made the treatment positive and sure.

Correct diagnosis of diseases of the rectum by the general practitioner is the exception rather than the rule. This is due in the main to careless and unskillful examinations. Too many of us have been diagnosing every case as "piles" without a systematic and careful inspection of every part, even taking the patient's work for it.

Many serious rectal conditions have been overlooked that would have been speedily relieved had the medical attendant made a careful examination and diagnosis at that time.

Proctology should be placed upon the same basis as other branches of surgery, and a thorough course given by lecture and clinic, that the student may begin practice with a reasonable working knowledge of this important subject.

You cannot depend upon subjective symptoms alone, but a thorough ocular examination with the proper instruments is imperative.

The careful examination of the external parts of the anus will tell you much; for instance, a fistula may be located by the discovery of its tortuous canal, which feels like a pipe stem beneath the finger, or by pressing about the parts you will many times squeeze out pus, and in that manner locate a small sinus or fistula.

Again the pain of the examination will lead you to hunt for a fissure or ulcer. The discoloration of the parts will prove a discharge more or less constant, and you will find a serious rectal or colonic trouble above the rectal pouch.

A tight or thickened sphincter muscle will indicate a more or less recent trouble, a flabby anus and sphincter muscle will indicate an old chronic disease. Pruritus means canals of some sort which don't belong there and usually contain pus. Perhaps a berry seed became lodged in one of the crypts of Morgagni and set up an ulceration.

Out of 150 cases of "piles" referred during my service to the rectal clinic of one of our large hospitals, less than half had hæmorrhoids of any kind, but all had more or less severe chronic rectal disease.

In my private practice I find about 30 per cent. of the cases referred to me as hæmorrhoids are not suffering with that affliction, but most of them have a far more serious trouble, and very much less amenable to treatment. I have never seen a case of hæmorrhoids that did not have a chronic proctitis or some other inflammatory condition present, and to cure the hæmorrhoids, which is easy, and not attend to the prior conditions, which were the original cause of the hæmorrhoids, would be but putting off the day of reckoning, as there would be more hæmorrhoids come again as long as the conditions which caused the first ones remained.

I should like to report a case to illustrate this.

Mrs. G. H., æt. 42, married, multipara, was referred to me by Dr. Harner, who had been treating her for chronic diarrhœa for some months previous without improvement. The doctor had made an ex-



amination of the rectum but could not make a satisfactory diagnosis. She had been under the care of two of our top notch prescribers up State, but still the discharge persisted. Temperature, 100; weight, 128; normal, 160. Family history not good, as a sister had died of tuberculosis; she was weak, anæmic, anorexia, four to six offensive stools a day, abdomen markedly tympanitic, night sweats and insomnia.

Digital examination revealed nothing of importance except a hypertrophied sphincter muscle, the proctoscope showed the inflammation did not extend above six inches, the sigmoid was normal, this proved the trouble to be below, and a careful hunt was made and a small sore spot located between the sphincter muscles in the bend of coccyx.

This was injected with 3 per cent. novocaine, and explored, and a small glass marble was removed. The patient had no knowledge how it got there or how long it had been there. I find in literature some cases reported in which various articles have been found in the rectum, presumably introduced in childhood and remaining dormant until late in life; but I believe this to be the glass marble record.

The wound was curetted and the patient made a good recovery. the discharge or "diarrhœa" disappearing promptly.' The doctor stated to me he had almost given up in despair hunting remedies having "the urging to stool, tenesmus and offensive stool" symptoms. I believe in the indicated remedy, but I also believe we should use every other means at hand to relieve the sick.

If I may be allowed to report another case I may be able to illustrate still another point in the necessity for careful diganosis.

Mrs. H. M., referred to me by her physician at Albany, with a diagnosis of "hæmorrhoids" of the bleeding type; for the past five years. She was full blooded, nervous type, extremely bad tempered. She had been losing considerable blood at intervals of five to ten days. After some argument I succeeded in making an examination, and found the blood to come from two ulcers high up in the rectum; the bleeding points could readily be seen and cauterized; the inflammation was taken care of by irrigation at home; there has been no more bleeding, and she did not have "piles."

The point I wish to make here is that this patient was too modest to permit an examination to be made, and would not allow me to do so until I flatly refused to do anything for her unless I could base my opinion upon a careful examination. It is much better to let

them go than make a wrong diagnosis, as you are sure to lose them any way.

Ninety per cent. of all rectal troubles can be treated in your office without pain to your patient, detention from business or any inconvenience whatever, and the results are even better than you can do by a severe hospital operation. You can produce perfect anæsthesia by injecting one-eighth of one per cent. Beta-Eucaine or Novocaine, and open a small or large fistula painlessly. You can inject the same in regional anæsthesia or nerve blocking and do almost anything you wish.

A thrombotic pile may be opened and cleaned out by injecting sterile water. With Somnoform you may stretch the sphincter muscles as much as you wish, and the patient go home in an hour.

Most colleges are now including proctology in their curriculum and teaching the students the uses of the proctoscope and local anæsthesia. The intelligent use of these instruments in constipation, proctitis, muco-colitis and pruritis ani, where the applications may be made directly to the diseased membrane, is inestimable, and absolutely necessary in the cure of nearly all of these distressing cases.

A careful examination of the rectum will not only surprise you but will amply repay you in most of your patients suffering with chronic backache, headache, tired, aching legs, nervous twitchings, indigestion and flatulence, rheumatism and many other ills caused by congestion, impeded circulation and autointoxication.

The number of patients we see with constipation that have a prolapsed mucous membrane, from years of drugs and straining at stool, is amazing. We can replace the membrane and inject some phenol solution, setting up an irritation sufficient to form an adhesion to the muscular wall, and the result is marvelous in the estimation of the patient.

In the same manner by placing a tampon in the rectum over the prostate gland you can relieve a great many bladder troubles.

In conclusion, then, I would say, examine every patient carefully for rectal trouble that is presenting chronic symptoms, and you will be able to cure a great many ills of long standing.

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THE CARE OF PATIENTS DURING PREGNANCY.\*

By Dr. Addison S. Boyce.

That much written of and thoroughly discussed subject of "The Care of Patients During Pregnancy" is not brought before you again this evening with the thought of presenting new or better methods of caring for our confinement cases, nor with the thought of presenting the old methods in a new or better light, but rather to solicit a discussion as to a way by which our theoretically perfect methods of caring for the patient from the early months of pregnancy, may be made more practical and their value more fully appreciated by the patient.

A large percentage of the confinement cases in our large cities receive no care whatever during the first seven or eight months of pregnancy. The records in our maternity, and other hospitals where maternity cases are taken, show that patients contemplating delivery at such hospitals, generally wait until a few weeks or days before the date of confinement before visiting that institution, and even then do not do so to seek professional advice, but merely to secure their beds for the confinement. Williams says that many hospital cases are never examined until labor is well advanced, and then it is not by any means rare to find a pathological condition, which no doubt called for treatment early in the pregnancy. Inquiry as to the reason of this neglect generally brings forth the answer that the patient did not know that any antepartum examination or care was necessary.

In the hospital where the better class of patients go for their confinement—patients who are in a position to pay for such services—are often told that they have been under the care of their own family physician, who does not take obstetrical work, but suggests their going to the hospital when labor began. Many of these patients calling during the last month, have never had an examination of any kind throughout the entire term, they having been under the impression that the family physician would have advised them had an examination been necessary. Apparently the importance of a regular, systematic examination of the urine, as a warning of one of the most dreaded complications, had never been thought of, nor

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the value of an early diagnosed malposition, in order that an attempt might be made to correct it in the latter months, or the physician be better able to cope with the abnormality when labor began.

The fact that the percentage of fatalities and complications is greater in hospitals than in private practice cannot be wholly accounted for by the reason so often given that the most cases are sent to the hospital. By far the great majority of maternity cases in our hospitals are cases that come in of their own accord, or are sent in by physicians who have absolutely no idea of the condition of the patient. Those cases sent in because a complicated confinement is anticipated, have generally been under the care of a physician, who retains the case, and, therefore, cannot be numbered with the regular hospital cases.

The difference in the antepartum care of those patients under the constant supervision of a conscientious physician, and the hospital case that waits until labor approaches before seeking care and advice, largely accounts for the fact that hospital records do not compare favorably with those of private practice. One other says: "To the neglect in the antepartum care of our patients can be attributed the deaths of untold numbers of women and children."

Out of five abnormal cases occurring in one of our city maternity hospitals in two weeks, not one had been seen before the seventh and one-half month, three had visited the institution two weeks before labor, and one case was persuaded to remain at the hospital the day she called.

This patient, 32 years of age, para. 2, gave the history of having given birth to a premature (eight months) still-born child two years previous. The delivery was followed by what the patient called a fit, during which she had bitten her tongue severely (a fact which seemed to have impressed her as the most important part of the affair). Her condition was as follows: Marked œdema of limbs and face, abdomen enormously distended and tense, so much so that the position could not be positively diagnosed by abdominal palpation. Pelvic normal, cervix soft and dilatable, admitting two fingers readily. Patient complained of some occipital headache and dizziness. She had not noticed whether or not the amount of urine was less than usual. Twenty-four hours after her admission to the hospital she had passed about 600 c.c. of urine. Urea, 14 grammes; albumen and casts abundant. The headache was worse, and the patient complained of dimness of vision. It was decided to empty the



uterus at once. This was about 3 P. M. At 6 P. M. the patient went into a condition of coma following a short convulsion. She was taken to the delivery room immediately; cervix dilated followed by version and extraction. The child, weighing about five pounds, was living. The enormous size of the abdomen was due to a condition of hydramnios. The mother died the following morning, having never regained consciousness.

If that patient, giving such a history, had called during the early months of pregnancy, and had received such treatment as the conditions called for, have we not reason to believe that the termination of that pregnancy would no doubt have been different? Of the five cases mentioned, one mother and three babies were lost. Not one of the patients that called before labor began returned to the hospital, as they had been instructed, but waited until labor was well advanced. In three of the cases the histories given and the conditions found at the time of the first examination, warranted an early interference. Instead, the patients arrived some hours after labor began, membranes ruptured, and the physicians left no choice of procedure.

The averaged private obstetrical record of four of our reliable physicians is as follows: Total number of cases, 3,500; number of mothers lost, three; babies, sixty-one. One physician who had 1,200 of this number, had lost not a mother and but eighteen babies. Among these 1,200 cases there were many presenting histories which would leave no doubt in the mind of any physician as to the outcome; had those patients not received the proper care from the early months. This physician says that if this record may be called a successful one, the success is attributable mainly to two things: 1st. The instruction of the mothers as to the necessity of supervision by the family physician from the early months. 2d. The effort on the part of the physician to carry out in every case the treatment essential to that particular case from the time pregnancy was diagnosed.

There is no doubt in the minds of most physicians but that the chief advance in obstetrical success will be along the lines of more careful and better antepartum instructions and treatment, for which we must look to the physician, whether or not he or she does obstetrical work. The fact that a physician does not take that line of work, does not excuse him or her from the neglect of advising their patients to early consult a competent obstetrician. It is no longer safe to allow a woman to reach the sixth or seventh month before

making use of every available means of ascertaining her exact condition. We say no longer safe; it never was safe; but woman's absolute change in the manner of living during the past twenty-five years is partly responsible for the fact that there is often a pathological condition existing at the beginning of the pregnancy, which is aggravated by the increased demand on the organism. A complete history taken during the early months of pregnancy becomes of great value at the time of labor. The value of a thorough investigation of a previous difficult labor cannot be overestimated. A complete personal history which takes into consideration particularly those diseases which result in lesions of the kidney, or heart, or those diseases which result in the production of pelvic deformities, as rachitis, spinal curvature, etc., the present history containing the date of last menstruation and all important symptoms which have occurred, particularly those symptoms attributable to renal insufficiency. A urinalysis made every month for the first six months, then every two weeks or more, often, if any kidney complications present themselves, will rid the physician of a feeling of guilt, should eclampsia develop out of an apparently clear sky. The general routine of specific gravity, color, odor, reaction, the presence or absence of sugar and albumen is not sufficient. The fact that albuminuria occurs in about 40 per cent. of all obstetrical cases shows the necessity for a microscopical examination to ascertain the presence or absence of casts. The investigation of the nitrogenous elimination of the patient, as indicated by the amount of urea, has become to the physician a criterion as to the condition and proper treatment of the patient.

The proper antepartum care of the breasts and nipples may spare the physician some after problems in arithmetic while endeavoring to figure out those modified milk formulæ which so often have a tendency to come up as fast as the figures go down.

The possible existence of a deformed pelvis should be borne in mind when we consider that according to Williams contracted pelvis occur in 13.1 per cent. of all American women; 19.83 in the colored women. The recognition of a pelvic deformity is of importance. It has been truly stated that one must learn pelvimetry if he is to do intelligent obstetrics. External measurements alone are of uncertain value in determining the type and extent of the deviation from the normal.

Those cases that terminate in spontaneous delivery while prepara-



tions are being made for a Cæsarean section, are often examples of limited pelvimetry. The true extent and the obstetrical significance of a deformity can only be ascertained by careful exploration of the pelvic cavity by vaginal examination, instrumental pelvic measurements and palpation.

The incorrect diagnosis of position and presentation are responsible for a great many of our still born births and maternal injuries. Some of the difficult forceps deliveries, necessitating almost superhuman strength and resulting in the delivery of a still-born child, are the result of an effort to deliver posterior positions without rotating, the diagnosis, if made at all, having been that of an anterior position or the rotation incomplete.

Emergencies occur more frequently in obstetrics than in any other branch of medicine, and they occur very often when most unlooked for, generally because the physician has not had the opportunity to know enough about the condition of the patient to look for any particular difficulty. An expected difficulty generally has a good prognosis. The patients in whom we look for trouble are the ones in whom we have diagnosed some abnormal condition, and who have been under our care and treatment.

We believe that the careful observation of symptoms during pregnancy, and the administration of the remedy called for by those symptoms, will not only often correct a pathological state, but will put the patient in a condition to *better* cope with those abnormalities which cannot be altered by medication.

When we think of the thousands and thousands of American women who are approaching motherhood and who are absolutely ignorant concerning the care that is necessary during pregnancy, and when we consider the thousands of lives that are lost annually because of the ignorance, we wonder if this is not a subject of sufficient magnitude to warrant our making an effort to instruct our women in this subject, which is of such vital concern to them and to their families. Such education would be of public benefit by saving the lives of thousands of women and children.

By educating women as to the necessity of antepartum supervision and the care they have a right to expect from the time they engage a physician to attend them during pregnancy, the standard of obstetrical work will be raised among physicians who have lowered it by antepartum neglect, and will open for the conscientious obstetrician a field of unlimited usefulness.

## EDITORIAL

### FIFTY HONORABLE YEARS.

April 12, 1860, by act of Legislature, "The Homœopathic Medical College of the State of New York, in New York City," was duly incorporated and given charter privileges. In the fall of that year the first session opened under the direction of Jacob Beakley, Professor of Surgery; Isaac M. Ward, Professor of Obstetrics; William E. Payne, Professor of Practice; Franklin W. Hunt, Professor of Clinical Medicine; Mathew Semple, Professor of Chemistry; John de la Montagnie, Professor of Anatomy, and William W. Rodman, Professor of Physiology. So well did they run that twenty-seven men graduated the next spring. Of these, we regret to say, all but a bare half dozen have left the living profession.

That was the first year of our history. It was a good year, prosperous, enthusiastic, and pregnant with promise for the future. We are now closing our fiftieth session, which, we trust, gives us as rosy and hopeful an outlook as did that first one. But how the whole realm of medicine has changed since that long ago! Were the old school contemporaries of our first class to testify in the presence of the graduates of any medical college of to-day, regarding the nature, origin, and treatment of any disease, it could not but excite mirth and derision.

In that day in the old school a standard work on Practice was written by John Mackintosh, of Edinburgh University. The fourth American edition uses this language: "In the severe forms of measles, bleeding is often necessary during the eruption of fever, when the pectoral symptoms run high and appear threatening, and also when coma and convulsions take place. I was called to see a fine boy of two years of age, who, during the eruptive fever, was seized with convulsions in the night, at the period when the eruption ought to have made its appearance, and from whom nine ounces of blood were taken. Next day he had nine or ten leeches applied to his head."

In the bowel complaints of children Mackintosh advised "a little thin arrow root, one small dose of calomel, followed by a little castor oil, and an occasional teaspoonful of chalk mixture, together with



the warm bath, will be *all that is required.*" (Italics ours.—ED.) In severe cases "five or six half grain doses of calomel, or one grain doses of hydrargyus cum creta, given either at night or in the morning, followed by an occasional small quantity of castor oil, and attention to the diet, will be sufficient to put the child in a fair way of doing well." (In heaven?) "The warm bath is to be used morning and evening; and I have found powders composed of calomel, aromatic powder, and Dover's powder, with or without rhubarb, proportioned to the age of the patient, highly useful. To a child of three months old, I would give half a grain of calomel, the same quantity of Dover's powder, and two of aromatic powder, every three, four, or six hours; to a child under that age, a somewhat smaller quantity of Dover's powder may be given, and it should be increased to those who are older. If the feverish symptoms still continue, a leech should be applied, or a stimulating embrocation rubbed upon the abdomen. It is always safe practice to apply a leech early, which is not only justified, but loudly demanded, by the appearances on dissection, when the mucous membrane is seen, not only in a high state of inflammation, but also of ulceration. *My museum contains many specimens and drawings of such morbid changes.*" (!) (Italics ours.—ED.)

The old school has vitally changed since that period, and this sort of treatment would be laughed at by them as by us. All medical colleges, too, have progressed since then. With the years has come wide knowledge of the nature and origin of disease. With this learning has come great progress in sanitation, hygiene, and immunity. In the old school these changes have diminished the dose, decreased the number of drugs, and developed a skepticism, at least an agnosticism, as regards all therapeutics. In that day homœopathy was an organized protest against drugging, to-day it is the standard bearer of continued faith in therapeutics.

That the New York Homœopathic College has succeeded is evidenced by the fact that twelve hundred living graduates are cultivating the medical field, and are looked upon as among the most skillful of the workers. Of four hundred colleges represented in the medical profession of the Empire States, but three other colleges have more representatives than the New York Homœopathic. Our graduates are filling responsible public positions from school physicians to Commissioner of Health of New York State. We are represented in practically every State in the Union and in many

foreign countries. The president, vice-president and secretary of the American Institute and six of its fifteen trustees are graduates of this college. Not a homœopathic college faculty neglects to number one or more from this institution, and several deans are loyal sons. A United States Senator, the president of a great university, and the mayors of several American cities came out of this college.

The institution itself has marvellously grown in fifty years. When the Alumni come back, as they will in large numbers next June, they will find few of the old landmarks. They will find an institution busy as a bee-hive, differing from every other medical college in New York, at least, in one particular. Whereas every other medical college is an annex to some hospital, this college has a hospital as much its own and as much an integral part of the college itself as is the laboratory of pathology or the dissecting room. In this hospital will be found between one and two hundred beds, all full. Last month the ambulance made over five hundred calls, and in 1909 patients of the dispensary made visits numbering between forty and fifty thousand! The corporation has holdings of upwards of a million dollars, and more in sight. Are not these fifty honorable years?

C.

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#### BROOKLYN NOTES.

Dr. Harold A. Sanders, '05, is recovering from a severe attack of influenza and tonsilitis.

Dr. Wm. C. Thompson, '03, has left Brooklyn and settled in Connecticut.

At the February meeting of the County Society, Dr. Richard Haehl, of Stuttgart, editor of the *Allgemeine Homœopathische Zeitung*, spoke most interestingly on Hahnemann as a hygienist, and also of his own trips to the various scenes of Hahnemann's labors.

Dr. Gregg Custis Birdsall, '04, of Washington, recently paid a flying visit to Brooklyn.

Dr. William Diehl, Jr., died Monday at his home, 150 Cornelia street. He was born in Brooklyn February 8, 1863, and was the son of the Rev. William Diehl, pastor of the First German New Church of Brooklyn. He graduated from the New York Homœopathic College in 1891, and was a member of Kings County Homœopathic Medical Society and the First German New Church. He leaves his



father, a widow, Selma, two daughters, Selma and Gladys, a brother, Philip, and a sister, Mrs. Anna Knapp, of Baltimore, Md.

Dr. Richard Haehl, of Germany, was the guest of Dr. Stuart Close on March 7th, and gave a memorable talk before a number of Brooklyn physicians, relating the ways in which he discovered Hahnemann's lost manuscripts and medicines. He found a sixth edition of the *Organon* ready for the press, and all of Hahnemann's medicines, none of which were above the 30th potency.

At the March meeting of the County Society Prof. Chas. W. McDowell spoke on "General Sanitation and Military Hygiene in Japan," illustrating his remarks by lantern slides. After showing military hygiene as carried out in the Russo-Japanese war, he turned to general sanitation, as it was applied to the lives of the great mass of the people. He regarded the large amount of phthisis in Japan as due to three sources, the custom of converting the houses into air-tight boxes at night, the absence of pavements, permitting the spread of bacilli with the dust, and the absence of sewers. Human excreta are used as fertilizer, there being too few animals in Japan to fill this want. The night soil in the cities is collected at dawn and carried to the fields, where it is poured into earthenware cisterns three or four feet deep, from whence it is dipped as needed, and scattered over the fields. Here is a fertile source of parasitic disease, and one which lends a foul odor to every landscape.

Dr. Desidero Roman, senior surgeon to St. Luke's Hospital, Philadelphia, spoke on "Surgical Intervention in the Domain of Medicine;" taking as examples the Morris Robertson operation in cirrhosis of the liver, renal decortication in cirrhosis of the kidney, and transplantation of tendons, nerve and blood vessels in general.

Dr. Jos. H. Fobes spoke on "Gonococcic Peritonitis in the Male." He said that it had been proven that the gonococcus did attack other than mucous surfaces, though Gumm denied this in '91. He cited what he believed to be the first reported case in which pure cultures of the gonococcus were grown from the exudate of a case of diffuse peritonitis in a male, and spoke of the use of antigonococcic serum and argyrol irrigations in the disease after section.



## OBITUARY.

George Howard Palmer, M. D., died suddenly at his residence, 92 Hancock street, Brooklyn. He was born in 1862, and was the only son of A. Judson Palmer, M. D., and Maria D. Palmer. He was graduated from the New York University Medical College in 1884. He had been in practice ever since in this city. In 1895 he married Marie Estelle Clifton, and had been a member of the Central Congregational church for many years. He leaves a widow and two children. Dr. Palmer had been held in very high esteem in the medical profession, and his death will be a great loss to the profession as well as to his many friends.

Dr. Newton H. Traver, '61, of Lewistown, Mich., died in the Harper Hospital, Detroit, February 2, 1910, from shock following a surgical operation. He was 72 years of age.

Dr. Wm. H. Blakely, '72, died at his home in Bowling Green, Kentucky, January 25, 1910, from acute gastritis, æt. 68.

Dr. Rollin D. Gray, '71, of Flushing, N. Y., died on March 5, 1910, at the home of his daughter in East Orange, N. J., from cerebral hæmorrhage, æt. 69 years. He was a nephew of Dr. John F. Gray, one of the first homœopaths in this country.

Dr. L. R. Kaufman, '04, of New York City, has had the honor of an appointment as visiting physician to and assistant secretary of Executive Council of the French Maternal School of 328 W. 28th St., Manhattan, which has a daily census of seventy-five children from two to ten years of age.

The Flower Hospital Alumni Association of internes held a beefsteak dinner at Healy's on Monday evening, March 7th. The officers for the ensuing year are as follows: B. B. Sheldon, M. D., President; L. R. Kaufman, M. D., 272 W. 84th Street, New York City, Secretary-Treasurer. Any physician holding the Flower Hospital certificate is eligible. Dr. Wm. Todd Helmuth was elected an honorary member.